CERTIFICATE OF VISUAL EXAMINATION

TOP PORTION MUST BE COMPLETED BY APPLICANT

FAX NUMBER (801) 957-8698

UTAH DRIVER LICENSE DIVISION

PO BOX 144501
SLC UT 84114-4501
PHONE NUMBER (801) 957-8690
www.driverlicense.utah.gov

Last Name **First Name** **Middle or Maiden Name** **Date of Birth** **Driver License or Driving Privilege Card Number**

Street Address **City** **State** **Zip Code** **Social Security Number / ITIN**

Mailing Address **City** **State** **Zip Code**

☐ If either your residential or mailing address has changed, please mark the box and print the new address above. By submitting this change of address, I affirm, under penalty of law, that this is my true and correct Utah residence address and/or mailing address. If you have a commercial license you will need to appear at a commercial driver license office to obtain a new license with your correct address within 10 days.

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P.O. Box 144501, Salt Lake City, Utah 84114-4501. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information will be classified as a private record in accordance with GRAMA (UCA 63G-2-202). Individuals who are entitled to have a "private" record disclosed to them are limited to the subject of the record, a parent or legal guardian of an unemancipated minor or legally incapacitated individual, an individual with power of attorney or a notarized release signed by the subject of the record, or an individual with a court or legislative subpoena.

Applicant's Signature X: **Date**

****** Form will not be processed without signature******

(Visual Acuity Report and restrictions to be filled out by Health Care Professional or Driver License Examiner)

Visual Acuity	**Are lenses required while driving?** ☐ **No** ☐ **Yes**		**Visual Field 120°** **60° to both right and left** **Private and Commercial** CDL COLOR BLIND ☐ YES ☐ NO	*For office Use Only: DLD Screening* Date of Exam _____
	Without Correction	**With Correction**		
RIGHT EYE	**20/**	**20/**	☐ **YES** ☐ **NO**	**Signature**
LEFT EYE	**20/**	**20/**	☐ **YES** ☐ **NO**	**Emp #:**
BOTH EYES	**20/**	**20/**	☐ **YES** ☐ **NO**	**Station:**

Circle Profile Level:

1	2	3	4	5	6	7	8	9	10
None	None	None	None	Speed	Road test*	MAB	MAB	MAB	No Driving

*With recommended restrictions of speed, area and daylight only **Shaded areas require Medical Advisory Board review**

Recommended Restrictions: Speed-posted 40 mph or less Area Daylight Only

YES NO If visual fields are less than 120°, are they at least 90°, with 45° to both the right and left of fixation?

YES NO If visual fields are less than 90°, are they at least 60°, with 30° to both the right and left of fixation?

YES NO With regards to driving safety, does this person have any medical conditions of significance? If so, please list condition: _____

Indicate the etiology of the visual impairment:_____

How stable is the visual condition? _____

Recommended interval for examination: ☐ Standard for Profile Level ☐ Other: Specify Interval_____

I recommend this driver complete a driving skills test in an appropriate vehicle. (Drive test not available for level 10)

Date of Examination *(Current within 6 months)* **Printed Name of Health Care Professional** **Signature and Degree** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**